THE ROLE OF BLUE CROSS AND INSURANCE COMPANIES IN INSURING GROUP PRACTICE*

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GROUP practice prepayment is in a pivotal stage of its development. After a few decades of dedicated effort to establish, defend, operate, and spread such plans, only little more than 4 million people are currently enrolled. The growth of group practice, even after all appropriate allowance for the obstacles, can hardly be called infectious. It was nearly invisible and almost ignored when the nation adopted its health insurance plan for the aged. By a late retrieve, group practice plans were permitted to participate, and a precedent may have been set whereby a single insurance plan recognizes both group and solo practice and provides appropriate reimbursement for each.

Group practice is now growing but largely without associated prepayment. The advantages both for physicians and patients are thereby diminished. The payments made to groups by insurance and prepayment carriers are predicated on the fees and features of solo practice. They provide a windfall for some services but not enough coverage for others; on the whole they do not support the group as well as an integrated prepayment plan does. More important, if groups continue to form on a large scale without committing themselves to serve defined populations, losses may occur in the process and practices may become entrenched that would be hard to reverse.

Financing programs continue to ignore the availability and the organization of the services they pay for. New and larger programs are following in these footsteps to the point of impairing their ability to function and of contributing to a growing general inflation in medical care costs. The futility of the big "buy-in" without concurrent change in the organization of care is becoming increasingly evident. Our prin-

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cipal program of medical aid for the poor is being curtailed. Our new health insurance for the aged is in similar straits, but instead of reducing benefits, its contributions have been already raised to a degree that makes previous rate increases seem idyllic in retrospect. Moreover, there is no evidence that these problems are merely transitional; on the contrary they will more likely continue until the organization of care is materially improved.

If group practice prepayment fails in the near future to acquire the critical mass needed to help deal with several current crises—in cost, in manpower, in extending care in core cities and rural areas, and in the assimilation of new knowledge and new technology; if it fails to keep more in step with the growth of groups; if it fails to develop qualitatively; if it remains a small movement of unfulfilled promise—other and radically different measures may have to be taken to extend access to care and to improve its organization.

That is why the presentations by Eugene Vayda, Charles A. Siegfried, and David W. Stewart are so especially important. The prospects for the further growth of group practice prepayment and the directions it may take may well depend on the development of the themes we have heard today.

Dr. Vayda has demonstrated that group practice prepayment works and that it can be extended. The Community Health Foundation in Cleveland, one of the most promising of the newer plans, is based on what Dr. Vayda calls the "genetic code" or the classic theories on which group practice prepayment has thus far been grounded. Where applied, these theories have on the whole acquitted themselves well. Considering the natural history of such movements—the vast difficulties in initiating them, the eventually diminishing opposition, and the accumulation of experience on which new efforts can be grounded—there is every reason to expect that other communities will successfully follow this pattern. Providence, Denver, and a few other cities seem ready to do so. However, the formation of each such plan is still a slow and difficult process. The resources needed to build them are limited. And a gnawing question persists whether this progression and procedure, even if accelerated, will suffice. The genetic-code analogy falters mainly on grounds of the relative infertility, at least thus far, demonstrated by such plans.

The possibility that group practice prepayment may also be able to grow in other ways is raised by Messrs. Siegfried and Stewart. They

represent the established prepayment and insurance plans that cover most Americans. If, along with their usual offerings, such plans are willing to underwrite group practice on a suitable basis, group practice prepayment could conceivably grow further and faster and acquire greater relevance to today's needs and challenges.

In explorations with the Harvard Community Health Plan around which some of these ideas are crystallizing, Blue Cross and some leading insurance companies have already shown that they are indeed interested in expanding benefits in new ways. They are ready to finance comprehensive service benefits. They are looking for a closer collaboration with medicine. They welcome improvements in the delivery system that would make possible further progress both in providing care and in underwriting its cost. Though not yet concluded, these explorations give us every reason to expect that the carriers will participate in the program, help recruit the subscribers, finance the costs of operating and, possibly, those of starting the medical service.

The sheer possibility that the mass financing agencies will no longer stand apart from the delivery of care but that through various medical and community intermediaries they will now participate in and encourage improvement in the organization of care is a heady prospect. If such arrangements work, group practice prepayment could increase its enrollment several times over. It could acquire another enrollment force that is large, able, and ready. It could acquire aid in starting and managing such programs on a nationwide basis wherever they are needed and desired. It could obtain support for acquiring and equipping the needed facilities. It could attract and serve such new sponsors as medical schools, medical groups, hospital staffs, and new community agencies who want to participate in prepaid group practice but may not be able to initiate and run prepayment plans of their own. It could liberate energies that, however necessary in the past, were devoted to essentially defensive pursuits and resulted in duplication of effort. It could enable new participants, freed of the need to build and run fiscal agencies, to devote their efforts to the further development and improvement of medical practice; to identifying, training, employing, and evaluating new kinds of health personnel; to applying the newest technologies; to advancing further the depth of protection. Group practice prepayment could thus not only be extended but updated and improved as well.

Understandably this new approach is accompanied by many prob-

lems, questions, and risks which need to be acknowledged and understood. Will the mass carriers regard group practice as just another and minor offering, or will they develop it supportively and sensitively so that its needs are met and its potential achieved? Is it really possible for them to serve effectively both group and solo practice or will they be subject to so much pressure from the bulk of their business sources as to provide inadequate support for group practice options? Will they accept those features that are essential to group practice prepayment or seek to make it conform to the customary claim-by-claim practices? Will they press for the fee-for-service features which would deprive group practice prepayment of one of its principal advantages and restore the incentives for more services as the way to receive greater remuneration? Will medical schools, medical groups, hospital staffs, and others newly entering such arrangements be sufficiently concerned with improving care and serving the community or will they bring a much weaker commitment than those who heretofore sponsored group practice prepayment?

If group practice prepayment is to enter the mainstream of American medical life it must enlist or create new fiscal agencies, acquire new sponsors, serve new subscribers, and meet new needs. If it is to grow on a larger scale under new auspices, it is bound to change. It will have to shed a tendency toward sectarianism and accept some of these risks.

An expansion of group practice prepayment may thus follow another timely biological analogy: there may have to be institutional transplantation, which is essentially what would happen if the mass prepayment plans now link up with group practice. This will not be easy—at least initially. Rejection and immunological reactions are to be expected. The elements to be joined have different origins. They feel differently, think differently, and react differently to a great many fundamental matters. Still the coming together of the mass carriers and group practice is more than mutually advantageous; it is necessary. Once mastered, such transplantations may become as commonplace as the grafting of plant tissues. The fruits of group practice may well flourish on the widespread roots of mass prepayment and insurance.